



DENTAL HISTORY

Date _____

Name _____
Last First MI MR MRS MS DR

Welcome! So that we may provide you with the best possible care please complete both sides of the Dental/Medical history form.
All information is completely confidential.

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full mouth x-rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____

Why was this treatment never performed? _____

Male ___ Female ___ SS#: _____

Date of Birth: ___/___/___ Age: _____

Home Address: _____

CITY STATE ZIP

___Single ___Married ___Divorced ___Widowed ___Separated

Hm# (___) Cell# (___)

Wk# (___) Ext: DL#

Email Address _____

Employer: _____

Employer's Address: _____

Occupation: _____

Where & When are the best time to reach you? _____

Whom may we Thank for referring you? _____

Previous/ Present Dentist: _____

Last Visit Date _____

Spouse Information

Name of Spouse: _____

Employer: _____

Wk# (___) SS#

Birth date: ___/___/___ Cell#

Person Responsible for Account:

Hm#: (___) Cell#

Billing Address: _____

Relation: SS#

Employer: _____

DL# _____

Primary Dental Insurance

Insurance Co. Name _____

Insurance Address: _____

Insurance Phone # (___) _____

Group# Policy#

Insured's Name: _____

Relation: Insured's ID#

Date of Birth: ___/___/___

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Address: _____

Insurance Phone# (___) _____

Group # Policy #

Insured's Name: _____

Relation: Insured's ID#

Date of Birth: ___/___/___

Insured's Employer _____

Employer's Address _____

Person to notify in case of emergency:

His /Her Name _____

Relation: _____

Wk#(___) Hm#(___)

Are you allergic to any of the following?

Aspirin	Y	N	Erythromycin	Y	N
Codeine	Y	N	Jewelry / Metals	Y	N
Penicillin	Y	N	Dental Anesthetics	Y	N
Tetracycline	Y	N	Latex	Y	N
Other	Y	N			

Please list any other drugs / materials that you are allergic to: _____